

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN4709	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/07/2011
NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, FT SANDERS			STREET ADDRESS, CITY, STATE, ZIP CODE 2120 HIGHLAND AVE KNOXVILLE, TN 37916		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments Complaint investigation #28968 was completed at NHC Healthcare, Ft Sanders on December 7, 2011. No deficiencies were cited under chapter 1200-8-6, Standards for Nursing Homes.	N 000			

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

N.H.A.

(X6) DATE

12/15/11

STATE FORM

6899

FVDY11

If continuation sheet 1 of 1

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